

MARYLAND CONFIDENTIAL MORBIDITY REPORT (DHMH-1140)

(For use by physicians and other health care providers, but not laboratories. Laboratories use form DHMH-1281)

STATE DATA BASE NUMBER
(Completed by Health Department)

SEND TO LOCAL HEALTH DEPARTMENT

NAME OF PATIENT – LAST		FIRST	M	DATE OF BIRTH MONTH DAY YEAR			AGE	SEX M <input type="checkbox"/> F <input type="checkbox"/>	ETHNICITY (Select independently of RACE) HISPANIC or LATINO: YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/>			
<small>(Maryland law prohibits the reporting of a patient's name for HIV infection.)</small>												
TELEPHONE NUMBERS Home: _____ Workplace: _____						RACE (Select one or more. If multiracial, select all that apply) American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other (Specify): _____						
ADDRESS				UNIT#	CITY OR TOWN			STATE	ZIP CODE	COUNTY		
OCCUPATION OR CONTACT WITH VULNERABLE PERSONS <small>(Check all that apply - include volunteers)</small> <input type="checkbox"/> HEALTH CARE WORKER (Include any PATIENT CARE, ELDER CARE, "AIDES," etc.) <input type="checkbox"/> DAYCARE (Attendee or Worker) <input type="checkbox"/> PARENT of a child in DAYCARE <input type="checkbox"/> FOOD SERVICE WORKER <input type="checkbox"/> NOT EMPLOYED <input type="checkbox"/> OTHER (SPECIFY): _____						WORKPLACE, SCHOOL, CHILD CARE FACILITY, ETC. <small>(Include Name, Address, ZIP Code)</small>						
DISEASE OR CONDITION				DATE OF ONSET MONTH DAY YEAR			ADMITTED YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE ADMITTED MONTH DAY YEAR			HOSPITAL	
CONDITION ACQUIRED IN MARYLAND YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> <small>(If NO, INTERSTATE <input type="checkbox"/> or INTERNATIONAL <input type="checkbox"/>)</small>		SUSPECTED SOURCE OF INFECTION				DIED YES <input type="checkbox"/> NO <input type="checkbox"/>	DATE DIED MONTH DAY YEAR			PREGNANT YES <input type="checkbox"/> NO <input type="checkbox"/> UNKNOWN <input type="checkbox"/> NOT APPLICABLE <input type="checkbox"/> WEEKS PREGNANT _____ DUE DATE _____		
LABORATORY TESTS - VIRAL HEPATITIS POS NEG DATE HAV Antibody Total <input type="checkbox"/> <input type="checkbox"/> _____ HAV Antibody IgM <input type="checkbox"/> <input type="checkbox"/> _____ HB surface Antigen <input type="checkbox"/> <input type="checkbox"/> _____ HB core Antibody Total <input type="checkbox"/> <input type="checkbox"/> _____ HB core Antibody IgM <input type="checkbox"/> <input type="checkbox"/> _____ HB surface Antibody <input type="checkbox"/> <input type="checkbox"/> _____ HCV Antibody ELISA <input type="checkbox"/> <input type="checkbox"/> _____ HCV Antibody RIBA <input type="checkbox"/> <input type="checkbox"/> _____ HCV RNA (eg, by PCR) <input type="checkbox"/> <input type="checkbox"/> _____ ALT (SGPT) level _____ ALT -Lab Normal Range: _____ to _____ NAME of LAB: _____			ADDITIONAL LAB RESULTS + PERTINENT CLINICAL INFORMATION + OTHER COMMENTS <small>(For lab results give SPECIMEN - TEST - RESULT - DATE - NAME OF LAB. Please attach copies of lab reports whenever possible.)</small>									

ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS) – ADDITIONAL CASE INFORMATION

ONLY physicians should report AIDS. Physicians reporting AIDS should use this form. ONLY laboratories should report HIV infection. Laboratories reporting HIV infection should use form DHMH-1281 and the patient's Unique Identifier instead of the name. Maryland law prohibits reporting of the patient's name for HIV infection.

CONDITIONS	HIV LAB TESTS	DATE	RESULT
WEIGHT LOSS OR DIARRHEA <input type="checkbox"/>	CD4+ T-cells < 200 per microliter		
SECONDARY INFECTIONS (PCP, etc.) <input type="checkbox"/>	ELISA		
OTHER CONDITIONS ATTRIBUTED TO HIV INFECTION <input type="checkbox"/> (SPECIFY):	WESTERN BLOT		
	OTHER (SPECIFY):		

SEXUALLY TRANSMITTED DISEASE (STD) – ADDITIONAL CASE INFORMATION

SYPHILIS: PRIMARY SECONDARY EARLY LATENT (LESS THAN 1 YR) CONGENITAL OTHER STAGE (SPECIFY): _____
GONORRHEA: UNCOMPLICATED PID RECTAL PHARYNGEAL OPHTHALMIA NEONATORUM OTHER (SPECIFY): _____
OTHER STD (Specify): _____

STD LABORATORY CONFIRMATION AND TREATMENT					
Specify STD Lab Test (e.g., RPR or VDRL, FTA – ABS, FTA – IgM, Darkfield, Smear, Culture, Other)			STD Treatment Given		
DATE	TEST	RESULT	DATE	DRUG	DOSAGE

TUBERCULOSIS (Suspect or Confirmed) – ADDITIONAL CASE INFORMATION

MAJOR SITE: PULMONARY EXTRAPULMONARY ATYPICAL (SPECIFY) _____
ABNORMAL CHEST X-RAY:
COMMENTS: _____

REPORTED BY	ADDRESS	TELEPHONE NUMBER	DATE OF REPORT MONTH DAY YEAR
<input type="checkbox"/> Check here if completed by the Health Department			

NOTE: Your local health department may contact you following this initial report to request additional disease-specific information.

Check here if you need more confidential morbidity report forms